

Medicaid Application Date: _____

Reason for denial: _____ (Attach copy of denial)

FINANCIAL INFORMATION:

Bank/Credit Union: _____

Address _____

(City) (State) (Zip)

Checking Acct. Balance: \$ _____ Savings Acct. Balance: \$ _____ (Attach most current copy)

Company Income Statement: \$ _____ (Attach copy)

Do you own your home? Yes No If yes, balance owed: \$ _____

Approximate Value of the Home: \$ _____ Monthly Payment: \$ _____

Are you renting? Yes No How Long? _____ Monthly Rent: \$ _____

Other Property Owned? Yes No Approximate Value: \$ _____

AUTOMOBILES:

Make: _____ Model: _____ Year: _____ Monthly Payment \$: _____

Make: _____ Model: _____ Year: _____ Monthly Payment \$: _____

Other Vehicles Owned: _____

Recreational Vehicles: _____

MONTHLY HOUSEHOLD EXPENSES:

Food	\$	Power	\$	Water	\$
Gas	\$	Telephone	\$	Sanitation	\$
Prescriptions	\$	Cable	\$		\$

OTHER DEBTS: List all debts owed but not previously listed below. If needed, use additional pages. Please include all medical bills, credit cards, insurance premiums, etc.

OWED TO WHOM:	BALANCE OWED:	MONTHLY PAYMENTS
	Total Owed:	

I hereby certify that the above information is true and correct. I authorize Munising Memorial Hospital to contact the employers and institutions listed on this application to verify its accuracy, if deemed necessary. I further authorize the employee/institutions to release such information to MMH.

PATIENT: _____ DATE: _____

SPOUSE OR LEGAL GUARDIAN: _____ DATE: _____

IMPORTANT - PLEASE READ

Completed form must be returned within 30 business days. This form will remain active and on file for three months. The following information must be provided with the completed application for assistance to be determined.

- Pay stubs for the past three months should be provided as proof of gross income
- Copy of last federal tax return (s)
- Copy of all investments i.e.: IRA, stocks, bonds, mutual funds, etc.
- Copy of all life insurance policy (s)
- Financial Assistance Application form must be filled out completely with all information listed
- Spouse or legal guardian, if applicable must sign application form before processing

If you are not able to provide the above information, please contact a Financial Counselor for alternative verification options.

ADDITIONAL WORK SHEET IF NECESSARY

OWED TO WHOM	BALANCE OWED	MONTHLY PAYMENTS
	Total Owed:	

Additional Comments Supporting Financial Assistance Need:

Financial Assistance Determination:

Date application received: _____ Received by: _____

Eligibility:

Assessed by: _____ Date: _____

Discount amount: _____ Patient notified on: _____